	DeanHeath ian	IN.	JECTABLE MEDICINES	SEARCH TIPS:			
		This reference guide is a partial listin are covered, not covered, or not yet	ng of the most commonly prescribed drugs under the medical benefit reviewed and whether a prior authorization is required. For coverage	This is a large donorment but you can search mighly and easily by dicking on	the binocular icon on your toolbar. It will then display a search box for you		
	Updated: 05/01/2024	review of any drug listed as not cov Dean Health Plan website for medic	ered, please complete the Exception to Coverage form found on the cal submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	to type in the name of drug you want to locate. If you do not know the corre the na	ct spelling, you can start your search by entering just the first few letters of ime		
Benefit		Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	Q2055	ABECMA	Idecabtagene vicleucel	Yes, through the Plan Pharmacy Services	ABECMA (Idecabitagene vickeurel)	ABECMA (Idecabtagene victeucel)	MAND Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 150-7), Chapter 15, \$50 Drugs and Biologicals for drups
Medical	19264	ABRAXANE	paditaxel protein bound	Yes, through the Plan Pharmacy Services	ABRAYANE (paciltaxel protein-bound particles)	ABRAYANE (pacifitaxel protein bound particles)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	19296	ACCORD	pemetrexed	Yes, through the Plan Pharmacy Services	ACCORD (permetroxed)	ACCORD (gemetrered)	MAYD Prior Authorization needed outlined in the Medicare Benefit Policy Manual Pub. 100-21, Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J3262	ACTEMRA (IV)	tocilizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with an Rheumatology specialist with authorization.	ACTEMBA IV (toclizumab)	ACTEMRA IV (tocilisumab)	
Pharmacy	13262	ACTEMRA (SC)	tocilizumab	Yes, through Navitus. Restricted to (in at least consultation with an Rheumatology specialist with authorization.		ACTEMBA SC Recitizumabi	MAID Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 500 Drugs and Biologicals for drugs MAID Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 500 Drugs and Biologicals for drugs
Pharmacy	10800	ACTHAR GEL	repository corticotripin injection	PHARMACY BENEFIT ONLY. Yes, through Navitus. Refer to members pharmacy benefit formulary for coverage.		ACTHAR GEL (repository conticetripin injection)	
Medical	10791	ADAKVEO	crizanlizumab-tmca	Yes, through the Plan Pharmacy Services. Restricted to an Hematology specialist with authorization.	ADAKVEO (mizanlizumab-tunca).	ADAKVEO (crisselirumab-tesca)	MAYD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2). Chapter 15, 550 Drugs and Biologicals for drugs.
Medical	19042	ADCETRIS	brentuximab vedotin	Yes, through the Plan Pharmacy Services	ADCETRIS (brentusimab vedotin)	ADCETRIS (brenturimab vedotin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19029	ADSTILADRIN	nadofaragene firadenovec-vncg	Yes, through the Plan Pharmacy Services.	ADSTILADRIN® (nadofaragene firadenovec-unce).	ADSTILADRIN® (nadofaragene firadenover-veng)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J0172	ADUHELM	aducanumab	None. Not Covered.	ADUHELM (aducanumab)		
Medical	C9167	ADZYNMA	ADAMTS13, recombinant-krhn	Yes, through the Plan Pharmacy Services	ADSYNMA (ADAMTS13 recombinant-krhn)	ADSYNMA (ADAMTS) 3: recombinant-lerbn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1454	AKYNEZO	(fosbetupitant/palonosetron)	Yes, through the Plan Pharmacy Services	AKYNE20 (fosketupitant/palonsetron)	AKYNEZO (fosbetupitant/palonosetron).	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11931	ALDURAZYME	laronidase	Yes, through the Plan Pharmacy Services. Restricted to (or in consultation with) medical geneticist or other prescriber specialized in the treatment of mucopolysaccharidosis with authorization.	at DUBAZYME (Saronidasa).	ALDUBAZYME (laronidase)	MANO Pror Authorization needed audined in the Medicare Benefit Policy Manual (Pub. 100-3), Chapter 15, 500 Drugs and Biologicals for drugs
Medical	19305	ALIMTA	pemetrexed	Yes, through the Plan Pharmacy Services	ALIMTA (cometrexed)	ALIMTA (pemetrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19057	ALIQOPA	copaniisib	Yes, through the Plan Pharmacy Services	ALIOOPA (conantisib)	AUDOPA (conantiib)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J2469	ALOXI	palonosetron	No Prior Authorization is Required	ALOXI (palonosetron)		See National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO.
Medical	Q5126	ALYMSYS	bevacizumab	As of 30,17,2004. Tirebev is the preferred Bevactismab product and does not require prior authorization. Avastin, Alymays, Mivasi and Vegatima prior authorization is required through the Plan Pharmacy Services. ""Prior authorization for bevactismab is not required when used for ophthalmological indication." "See the ALYMSOS (bevactismab) Policy for a list of applicable ophthalmological distances."	ph/MSVS (broakloumab)	ASSAMOTS (bevarioussab)	MAYO Prior Authoritation based on National Coverage Determination (INCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WII, II, MO.
Medical	J1426	AMONDYS	casimersen	None. Not Covered.	AMONDYS (casimersen)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	19999	AMTAGVI	lifileucel	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services			
Medical	10225	AMVUTTRA	viutisiran	Yes, through the Plan Pharmacy Services	AMVUTTRA (votrisiran)	AMOUTTRA (vutisiran)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17175, 17178, 17179, 17180, 17181, 17188, 17189, 17198, 17212	Antihemophilia Factor and Clotting Factor (Coagadex, RiaSTAP, Vonvendi, Confact, Tretten, Obizur, Novoseven RT, Feiba NF, Sevenfact)	coagulation factor v (human), fibrinogen concentrate human), von Willebrand Factor (precimisant), factor XIII concentrate (human), coagulation factor XIII A. subunit (recombinant), antihemophilic factor (prortine), coagulation factor VIII (recombinant), antihinbibor cragulant complex, Coagulation factor VIIIa (recombinant)-jecwi)	Yes, through Dean Health Plan Utilization Management Department. Restricted to an Hematology specialist with authorization.	ANTHHEMOREUS FACTORS AND CLOTTING FACTORS	ANTIHERADPHILIC FACTORS AND CLOTTING PACTORS	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	77182, 17183, 17185, 17186, 17187, 17190, 17192, 17204, 17205, 17207, 17208, 17209, 17210, 17211, 17214	Anthemophilic Factor VIII (Novoeight, Wilste, Nyrtha, Appharate, Hunard Sphantate, Lord Replantate, Lord Recombinate, Especial, Spirit, Recombinate, Especial, Application, Brockett, Application, Markette, Mark	(antihemophili factor (pecombinant), von Willebrand (actor/coaphice factor Vin complex human), factor/coaphice factor Vin complex human), factor/coaphice factor (moplex human), antihemophilic factor/con Willebrand factor complex factor/con Willebrand factor complex factor/com Viniterior factor complex factor (more factor), antihemophilic factor (pecombinant), antihemophilic factor (pecombinant) pecombinant (pecombinant), antihemophilic factor (pecombinant) pecombinant (pecombina	Yes, through Dean Health Plan Utilization Management Department. Restricted to an Hernatology specialist with authorization.	ANTHERMOREAGE FACTOR SEC	astheratowice factor un	MAYO Pror Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	17193, 17194, 17195, 17200, 17201, 17202, 17203	Antihemophilic Factor IX (Alphanine SD, Mononine, Profilnine, Benefix, Isinity, Ricubis, Alprolix, Idelvion, Rebinyn)	(coagulation Factor IX, coagulation Factor IX, factor IX complex, coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), coagulation factor IX (recombinant), chain	Yes, through Dean Health Plan Utilization Management Department. Restricted to Nematology specialist with authorization.	ANTHERACHMENT FACTOR IS.	ANTHERMOREUC FACTOR IS.	MAYO Pror Authorization needed outlined in the Medicare Serefit Policy Manual (Pub. 100-2), Chapter IS, \$50 Drugs and Biologicals for drugs
Medical	12277	APHEXIDA	motivafortide	Yes, through the Plan Pharmacy Services	SEMENTAL Amost submission	Admit NDA (montastorida)	
Medical	10256	ARALAST NP	alpha-1-proteinase inhibitor (human)	Yes, through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	ARALAST NP (Alpha-3-proteinase Inhibitor)	ARALAST NP (Alpha-1-proteinase Inhibitor)	MAMO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J0881	ARANESP	darbepoetin alpha	Yes , through the Plan Pharmacy Services	ARANSEP (darbegoetin alpha)	ARANSEP (darbepoetin alpha)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 3), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	C9072	ASCENIV (IVIG) - non-preferred	immune globulin (Human)	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of all other immune globulin products.	ASCENIV (NYG)	ASCENIV (IVIG)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions WI, IL, MD.
Medical	J9035	AVASTIN	bevacizumab	As of 03/01/2024: Zirabov is the preferred Bevacizumab product and does not require prior authorization. Awatin, Aymoy, Mivasi and Vogestima prior authorization is require through the Plan Pibamacy Services. "*Pfior authorization for bevacizumab is not required when used for ophtharinological indication." *See the AUTMSO; (bevacizumab) Policy for a list of applicable ophthal mological diagnoses.	AVASTN Beyorin maki	dutaSTM (Introduction made)	MATO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Actions (LCAs) for guidance where applicable for Jurisdictions WI, IS, MO.

	DeanHeath it	in IN	IJECTABLE MEDICINES	SEARCH TIPS:			
		This reference guide is a partial list are covered, not covered, or not ye	ing of the most commonly prescribed drugs under the medical benefit it reviewed and whether a prior authorization is required. For coverage wered, please complete the Exception to Coverage form found on the ical submit to the Plan Pharmacy Services and for pharmacy submit to Machine	This is a large document, but you can search quickly and easily by clicking on t	he binocular icon on your toolbar. It will then display a search box for you		
	Updated: 05/01/2024	review of any drug listed as not co Dean Health Plan website for med	revered, please complete the Exception to Coverage form found on the ical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	n the to hope in the name of drug you want to locate. If you do not know the convex qualitar, you can start your search by retaining just the first few letters of the name			
Benef		Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	Q5121	AVSOLA - non-preferred	infliximab-axxq	Yes, through the Plan Pharmacy Plan after failed trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialists with authorization.	AVSOLA (infliximab-axxq)	AVSOIA (infliximals-axxe)	MANO Prior Authorization based on National Coverage Determination (NCD), local Coverage Determinations (LCDs), and local Coverage Articles (LCAs) for guidance where applicable for brinderions WI, II, MO.
Medical	A9590	AZEDRA	iobenguane I-131	Yes, through the Plan Pharmacy Services	AZEDRA foberguine I-1311	AZEORA (inherquae i - 131)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drup
Medical	J9023	BAVENCIO	avelumab	Yes, through the Plan Pharmacy Services	BAVENCIO (avelumab)	BAVENCIO (avolumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 300 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9032	BELEODAQ	belinostat	Yes, through the Plan Pharmacy Services	BELEODAO (belinostat)	BELECIDACI (belinostat)	MANO Prior Authorization needed outlined in the Medicare Benefit Pulicy Manual (Pub. 100-3), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19036	BELRAPZO	bendamustine	Yes, through the Plan Pharmacy Services	BELRAPZO (bendamustine)	BELRAPZO (bendamustine)	MAMO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-7), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19034	BENDEKA	bendamustine	Yes, through the Plan Pharmacy Services	BENDEKA (bendamustine)	BENDEKA (bendamustine)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-7), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	10490	BENLYSTA (IV)	belimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.	BENLYSTA IV (belimumab)	BENLYSTA IV (balimumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmac	10490	BENLYSTA (SC)	belimumab	Yes, through Navitus. Restricted to (in at least consultation with) a Rheumatology, Dermatology, or Nephrology specialists with authorization.		RENLYSTA SC (belimumak)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 510 Drugs and Biologicals for drugs
Medical	10179	BEOVU	brolucizumab-dbll	None. Please see attached policy for criteria.	BEOVU (broludzumab-dbll)		MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Artides (LCAs) for guidance where applicable for Jurisdictions W, II, MO.
Medical	10179	BEOVU	brolucizumab-dbll	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical	19229	BESPONSA	Inotuzumab ozogamicin	Yes, through the Plan Pharmacy Services	8ESPONSA (incourumab ozogamicin)	RESPONSA (Inotuzumals-ozopamicin).	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drups
Medical	11556	BIVIGAM (IVIG), IMMUNE GLOBULIN	immune globulin (bivigam)	Yes, through the Plan Pharmacy Services	SINGAM (NIG)	BIVIGAM (TMG).	MAVO hirs' Authorization based on National Coverage Determination (PCD), Local Coverage Determinations (PCD), and Local Coverage Articles (ECA) for guidance where applicable for Arrividations WI, B, MO.
Medical	19039	BUNCYTO	blinatumomab	Yes, through the Plan Pharmacy Services	<u>BUNCYTO (binatumomab)</u>	BUNCYTO (binatumomab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19322	BLUEPOINT	pemetrexed	Yes, through the Plan Pharmacy Services	SLUEPOINT (pametrexed)	SLUEPOINT (pametrexed)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19044	BORTEZOMIB	bortezomib - preferred	Yes, through the Plan Pharmacy Services	BOSTEZOM/B.	BORTEZOMIB.	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD
Medical	10585	вотох	onabotulinumtoxin	No prior authorization is required.	BOTOX (onabotulinumtoxin)		MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	Q2054	BREYANZI	lisocabtagene maraleucel	Yes, through the Plan Pharmacy Services	BREYAND (lisocattagene maraleucel)	BREYANZ (Isocabtagene maraleusel)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
Medical	J0567, C9014	BRINEURA	cerliponase alfa	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the Late infantile Ceroid lipofucinosis with authorization.	BRINEURA (cerliponase alfa)	BRINEURA foorlippenase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12329	BRIUMVI	ublituximab-xiiy	Yes, through the Plan Pharmacy Services	SKUMMY** (ubliturimab-vily)	BRIUMVI* (ublicusimab sity)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Nub. 300 2), Chapter 15, 500 Drugs and Biologicals for drugs
Medical	Q5124	BYOOVIZ	ranibizumab	No. No prior authorization required	BYOOV2 ²⁰ (rainibizumab)	BYOOWZ** (rainibaumab)	MMO from Authorization based on National Coverage Determination (InCl), Local Coverage Determination (LCL), and Local Coverage Artistic (LCL) for guidance where applicable for samulations WE, K, MO
	Q5124	BYOOVIZ	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Store	Coming Soon	
Medical	19043	CABAZITAXEL	Cabazitaxel (Jevtana)	Yes, through the Plan Pharmacy Services	CABATITANEL (Invtanz)	CARATTAXE. (Sextana)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Puls. 100 2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	C2056	CARVYKTI	ciltacabtagene autoleucel	Yes, through the Plan Pharmacy Services	CARVYKTI foltacahtagene autoleuceli	CARPERT (citacabtagene autoleuroli)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	CASGEVY	exagamglogene autotemcel	Yes, through the Plan Pharmacy Services	CARVYKTI (ditacabtagene autoleucel)	CARVYKTI (ciltacabtagene autoleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J1786	CEREZYME	imiglucerase (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher DX. with authorization.	CEREZOME Emiglucorase) (Intravenduci)	CEREZYME (imighocorace) (Intravenous)	MAYO Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Prob. 100 2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5128	CIMERLI	ranibizumab	No. No prior authorization required	COMERLE (rankboum ta)		MATO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WII, II, MO
	Q5128	CIMERLI	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Pharmac	10717	CIMZIA	certolizumab pegol	Yes, through Navitus. Refer to members pharmacy benefit formulary for coverage. ***Please note this is not covered under the medical benefit.***			
Medical	12786	CINQAIR	redizumab	Yes, through the Plan Pharmacy Services. Restricted to a Pulmonology, Allergy, and Immunology specialist with authorization.	CNOCANE (rectinements)	CINCARR (realizzumab)	MAYO From Authoritation needed outlined in the Medicare Benefit Policy Manual (Puls. 100-3), Chapter 15, 500 Drugs and Biologicals for drug
Medical	J1932	CIPLA	lanreotide depot	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	CIPLA [lanreotide depot]	CIPLA (lanreotide depot)	MANO hirs Authorisation needed auditived in the Medicare Rendfi Pulsy Manuel (Puls 100-3), Chapter 11, 560 Orage and Riologicals (or drugs
Medical	19286	COLUMVI	glofitamab-gxbm	Yes, through the Plan Pharmacy Services.	COSUMVITE (glofitamab-pabm)	COLUMN* (glofitamab-pibm)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 500 Drugs and Biologicals for drugs
Medical	11448	COSELA	trilacidib	Yes, through the Plan Pharmacy Services	COSELA (trilacistis)	COSEA (triberish)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	C9166	COSENTYX IV	secukinumab	Yes, through the Plan Pharmacy Services	COSENTYX IV (senukinumah)	COSENTYX IV (seculinumah).	

		DeanHeath fan	INJECTABLE MEDICINES		SEARCH TIPS:			
And Process Appearation			This reference guide is a partial listing of the most commonly prescribed drugs under the medical benefit are covered, not covered, or not yet reviewed and whether a price authorization is required. For coverage review of any drug listed as not covered, please complete the Exception to Coverage form found on the Dean Health Plan website for medical submit to the Plan Pharmacy Services and for pharmacy submit to Novibus.		It git his is a large document, but you can search quickly and easily by dicking on the binocular con on your boolbur. It will then display a search box for you to hope in the name of drug you want to locate. If you do not know the commit spelling, you can start your search by entering just the first few letters of the name.			
Hear Reserve	Donnella		Daniel Names	Consideration of the Considera	Dalas Authorization or Destrictions	Deller	Polos Audiosissis Francis	MADO
		J Code		burosumab	Yes, through the Plan Pharmacy Services, Restricted to Endocrinologist.		Prior Authorization Form Chyswita (burosumab)	
	Medical	IACCE	CUVITRU (SCIG), IMMUNE	immune elebulie feruttui	of Metabolic Bone Disorders with authorization.	CONTRACTORIS	CHATCHISCASI	
Page						CYRAM74 (ramuricumah)	CYRAMZA (camurinumah)	
Page						DANOFINA (a. (a. ca.)		
						DAPZH SV Identeum bi		
		19144, C9062					DAZALEX FASPRO (daratumumato/hyaturomdas4-th))	
Heart Property of the Company of the	Medical	10589	DAXXIFY	daxibotulinumtoxinA		DAXXIFY* (daxibotulinumtoxinA)		MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
	Medical	17318	DUROLANE - non-preferred	sodium hyaluronate	TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflewa, Gelsyn-3. Visco-3. sodium hyaluronate. TriVisc. Orthovisc. Supartz FX	DURCHANE Reduce hysteriostal	DARGIANE (sodium hysterosiss)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (NCD), and Local Coverage Articles (NCA) for guidance where applicable for Jurisdictions Wij, Kj. MD.
Heart Book State Control of the Cont	Medical	10586	DYSPORT	abobotulinumtoxinA	No prior authorization is required.	DYSPORT (abobotuliniumtoxinA)		MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
	Medical	J9304	EAGLE	pemetrexed	Yes, throught the Plan Pharmacy Services	EAGLE (pemetressed)	EAGLE (pemetrexed)	NASH New Authoristive easiest inclined in the Medicare Result Public Manual Disk 1903. PLANNET'S SERVING and Reliabelance for every
Heave of the control	Medical	19063	ELAHERE	mirvetuximab soravtansine-gynx	Yes through the Plan Pharmacy Services	ELAHERE (mirvetuximab soravtansine-gyrox)	ELAHERE (mirvetuximab soravtansine-gynx)	
	Medical	J1743	ELAPRASE	idursulfase (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis II with authorization.	EUPRASE (idursulfase) (Intravenous)	ELAPRASE (dursulfase) (Intravenous)	MAYO Prior Authoritation needed audined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 500 Drugs and Biologicals for drup:
Seed 19 100 1000 1000 1000 1000 1000 1000 1	Medical	11413	ELEVIDYS	delandistrogene moxeparvovec-rokl)	None. Not Covered.	ELEVEDYS (delandistrogene moxeparvovec-rokil).		
Part Control	Medical	J3060	ELELYSO	talliglucerase aifa (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher 1 DX with authorization.	ELELYSO (talighorrase affa)	ELEXYSO (tallybucerace allo)	MAYO Prior Authoritation needed autimed in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 500 Drugs and Biologicals for drup:
Control Cont	Medical	12508	ELFABRIO	pegunigalsidase alfa-iwxj	Yes, through the Plan Pharmacy Services	ELFARRIO* (neguripakidase alfa-kwr)	ELFARRIC® (pegunigalsidase alfa-inni)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-3), Chapter 15, 500 Drugs and Biologicals for drugs
Heat Signal Sign	Medical	J1323	ELREXIFO	elranatamab-bcmm	Yes, through the Plan Pharmacy Services	ELREXIFO** (alranatamab-bcmm)	ELBEXIFO** (elranasamab-brown)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Section Sectio	Medical	19269	ELZONRIS	tagraxofusp-erzs	Yes, through the Plan Pharmacy Services	ELZONNIS (tagraxofusp-eras)	ELZONRIS (ragramsfusp-erzs)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.2), Chapter 15, §50 Drugs and Biologicals for drugs
Note 15 10 10 10 10 10 10 10 10 10 10 10 10 10	Medical	J9176	EMPLICITI	elotuzumab	Yes, through the Plan Pharmacy Services	EMPLICITI (elotuzumab)	EMPLICITI (elotuzumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Medical	19358	ENHERTU	fam-trastuzumab deruxtecan-rxxki	Yes, through the Plan Pharmacy Services	ENHERTU (fam-trastuzumals deruntecan-nolo)	ENHERTU (fam-trastuzumab derustecan-nxki).	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.2), Chapter 15, §50 Drugs and Biologicals for drugs
Fig. 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Medical	11302	ENJAYMO	sutumlimab	Yes, through the Plan Pharmacy Services	ENIAYMO (sytimlimab-jome)	ENIAYMO (sutimimab-jome)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.2), Chapter 15, §50 Drugs and Biologicals for drugs
March William Control of the Control	Medical	C9399, J3590	ENSPRYNG	satralizumab-mwge	Yes, through the Plan Pharmacy Services	ENSPRYING® (satralizumab-mwgo)	ENSPRYING* (satralizumah-mega)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
And Service Se	Medical	J3380	ENTYVIO	vedolizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Gastroenterology specialists with authorization.	ENTY/IO (vodolizumab)	ENTYVIO (vedolizumab)	MAPO hird Authorization needed outlined in the Medicare Benefit Holey Manual (Pub. 100-2), Chapter 15, 500 Drugs and Biologicals for drugs
Section of the company of the compan	Medical	J9321	EPKINLY	epcoritamab-bysp	Yes, through the Plan Pharmacy Services.	EPHNIX**** (epconitamals-byso)	EPINKXY** (encoritamah-byso)	MAYO Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pvb. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Media 755 DESTIX STATE DESTINATION OF THE PARTICULA STATE OF THE PARTICUL STATE OF THE PARTI	Medical	J0885	EPOGEN - preferred		does not require prior authorization. Epogen and Procrit prior authorization is required through the Plan	EPOGEN (separtin alfa)	EPOSEN (espositio alpha)	MAPO Prior Authorization based on National Coverage Determination (INCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO.
Reful J133 By LTXXA respondered and unit hydrocated, 315 and derivative and postportion seed postportion seed postportion seed postportion between the properties of the postportion seed postportion between the postportion seed postportion between the postportion between	Medical	J905S	ERBITUX	cetusimab		ERBITUX (cotusimab)	ERBITUX (conucimab)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical IIII (VINITY monocumula baega consultation with) a factornology of Philematodry Regulation with a factornology of Regulation Regulati	Medical	17323	EUFLEXXA - non-preferred	sodium hyaluronate, 1%	TRILURON will be the preferred hyaluronic acid products and do not require prior authorization. Monovisc, Durolane, Gel-One, Euflewa, Gelsyn-3. Visco-3. sodium hyaluronate. TriVisc. Orthovisc. Supartz FX	10/16/004 (sodium hyukunnato, 25)	6AFESOA (codum bealuscato, 25)	MAND from Authorization based on National Coverage Determination (MCS), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for furnisdations WH, II, MO
Medical 1355 VEXTEX environmental quantitation with part confidency (pulsplage) or inforcepromoting at part Message or inforcepromoting at a Message of inforcepromoting at a Message or inforcepromoting at a Message or inforcepromoting at a Message of inforcepromot	Medical	33111	EVENITY	romosozumab-aqqg	consultation with) a Endocrinology or Rheumatology specialists with	EVENTY (romosozumab-aqua)	EVENITY (romosozumab)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pvb. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Parmary In 1975 Indigum vs. through Narius. Redriced to a pediatric neurologist at a Miscolar Dystrophy Association on center with authorization. Medical 1828 DOMOTS Sa espirate Medical 07.71 THEA affected by Association of Sample of	Medical	J1305	EVKEEZA	evinacumab	consultation with) a Cardiologist, Lipidologist, or Endocrinologist	EVKEZA (svinacumah)	EVXEEZA (exinacumab)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical 5178 CREA althorough the process of the control of the con	Pharmacy		EVRYSDI	risdiplam	Yes, through Navitus. Restricted to a pediatric neurologist at a Muscula	FVRYSDL (risdiolam)	EVRYSDI (risdiplam)	
## BETR DETA AND ARTHUR STEEL OF STEEL	Medical	J1428	EXONDYS 51	eteplirsen	None. Not Covered.	EXONOYS 51 (eteplirsen)		
Medical 25.77 CYSEAVID althograph of the Authorization based on Neisonal Coverage Determination (ICCs), and Local Coverage Artificial (ICAs) for guidance where applicable for Juvidacions WI, N. MO.	Medical	J0178	EYLEA	aflibercept	None. Please see attached policy for criteria.	EYLEA (affibercept)		MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCD), and Local Coverage Articles (LCAs) for guidance where applicable for brindetions Wt. II, MO.
		10178	EYLEA	afilbercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
JOSZY EYESA HD affiliatespt EFFECTIVE OT/DIJ/2004. Yes, through the Plan Pharmacy Services Coming Scon	Medical	J0177	EYLEA HD	aflibercept	None. Please see attached policy for criteria.	EYLEA* HD (Affibercept)		MAMO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
		10177	EYLEA HD	affibercept	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	

	DeanHeath ian	IN.	JECTABLE MEDICINES	SEARCH TIPS:			
		This reference golde is a partial listing of the most commonly prescribed drugs under the medical benefit are covered, not covered, or not yet reviewed and whether a prior authorisation is required. For coverage review of any drug lessed as not covered, place complete the Exception to Coverage from Good on the Dearn Health Plan website for medical solent to the Plan Pharmacy Services and for pharmacy submit to Nachbus.		This is a large document, but you can search quickly and easily by clicking on to type in the name of drug you want to locate. If you do not know the correct the name of drug you want to locate.	t spelling, you can start your search by entering just the first few letters of		
Danella	Updated: 05/01/2024			Out- Authorization - Outsideline	Dellas	Dulan Australian I ann	Man
Benefit	J Code	Brand Names FABRYZYME	Generic names	Prior Authorization or Restrictions Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a medical geneticist or other prescriber specialized in	Policy FABRAZYME (applicidate)	Prior Authorization Form	MAPD MAP Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drug: and Biologicals for drugs
Medical	70130	TABLETINE.	again and a	the treatment of Fabry DX with authorization.			
Medical	10517	FASENRA	benralizumab	Yes, through the Plan Pharmacy Services. Restricted to Pulmonology, Allergy, or Immunology specialists with authorization.	FASENRA (bonralirumab)	FASENRA (benralitumab)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2); Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q0138, Q0139	FERAHEME - preferred	ferumasytol	As of 08/01/2022: VENOFER, INFED, FERRLECTT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INJECTAFER, MONDERMIC, TRIFFERI, and TRIFFERI AVNUI are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	FEBAHEME (Verumonytol)		
Medical	12916	FERRLECIT - preferred	sodium ferric gluconate complex	As of 08/01/2022: VENOFER, INFED, FERRILECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. NIECTAFER, MONORFER, TRIFFER, and TRIFERIC AVNN Jar the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	FERRECTT (sodium ferric plucosate comules).		
Medical	11744	FIRAZYR	icatibant	Yes, through the Plan Pharmacy Services	FIRAZYR® (icatibant)	EIRAZYN® (icatibant)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1572	FLEBOGAMMA/FLEBOGAMMA DIF (IVIG), IMMUNE GLOBULIN	flebogamma	Yes, through the Plan Pharmacy Services	PLEBO GAMMA/FLEBO GAMMA DIF (IVIG)	FLEBOGAMMA/FLEBOGAMMA DIF (IVIG)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	Q5108	FULPHILA	pegfilgrastim-jmbd	EFFECTIVE 03/01/2024: FULPHILA and NYVEPRIA are the preferred Pegiliparatim products and do not require prior authorization. Must have a falled trail of ZIECTEZD ON PULPHILA before coverage of Neulasta. UDENCYA, PYLNETRA, STIMUFEND and ZIEXTENZD require a prior authorization through the Plan Pharmacy Services. Pissae see Medical Policy for criteria	FLA PHILA Longfligeration ; mbdl	EXPMIA (negfligs assess subd)	MATO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, R, MO
Medical	10641	FUSILEV	levoleucovorin	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	RISKEY (involvements)	FUSI EV (levolescovorie)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19331	FYARRO	sirolimus albumin-bound	Yes, through the Plan Pharmacy Services	FYABRO (siralimus albumin-bound)	PYARRO (sirolmus albumin-bound)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5130	FYLNETRA - non-preferred	pogfilgranim-pbbk	EFFECTIVE 01/01/2024: FILI-PHILA and NYVEPRIA are the preferred Regilipparatine products and do not require prior authorization. Must have a false trial or JEXTENZO MON EUPHILA before coverage of Neulata: UDENCYA, FYLNETIA, STIMUFEND and JEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	PNINTER (soufilgration within	CELESTRA (seeffar axim sobb).	MAYO Pror Authorization needed outlined in the Medicare Benefit Policy Manual (Puls. 100 1), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19210	GAMIFANT	emapalumab-lzsg	Yes, through the Plan Pharmacy Services	SAMIFANT™ (emapalumab-izse)	GAMIFANT** (emapalumals-lasg)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11569	GAMMAGARD (SCIG), IMMUNE GLOBULIN	immune globulin, (gammagard liquid)	Yes, through the Plan Pharmacy Services	GAMMAGARD (SCIG)	GAMMAGARD (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	11557	GAMMAPLEX (IVIG), IMMUNE GLOBULIN	immune globulin (gammaplex liquid)	Yes, through the Plan Pharmacy Services	GAMMAPLEX (IVIG)	SAMMARIES (IVIS)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	J1561	GAMUNEX-C/GAMMAKED (SCIG), IMMUNE GLOBULIN	gamunex injection	Yes, through the Plan Pharmacy Services	GAMUNEX-C/GAMMAKED (SCK)	GAMUNEX-C/GAMMAKED (SCKG) IMMUNE GLOBULIN	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19301	GAZYVA	obinutuzumab	Yes, through the Plan Pharmacy Services	GAZYVA (obinutuzumab)	GAZYVA (obinutuzmab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	17326	GEL-ONE - non-preferred	hyaluronate sodium	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMAOVIS, and TRILLIRON will be the preferred hyallurinic acid products and do not require prior authorison. Memorisc, purplane, Gel-One, Fulfenza, Gelyn-A, Wisco-3, sodium hyallurinicate, Trivisc, Orthonics, Supratr EX, and Geniviscia Davie on the one preferred hyallurinic said products and prior authorization is required through the Plan Pharmacy Service. Recease the Michael Paricy for criteria	SEL-ONE (houturemake contium)	SEL CASE (translate sections)	MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Institutions WI, II, MO
Medical	17328	GELSYN-3 - non-preferred	hyalluronate sodium	As of 08/03/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TBILLIBON will be the preferred hybluronic acid products and do not require prior authorization. Motionoicy, Durabase, Gel-One, Euflenau, Geldyn A, Wisso J, sodium hybluroniate, InVisc, Otthorize, Superto TK, and Gellyn A, Wisso J, sodium hybluroniate, InVisc, Otthorics, Superto TK, and Genviroldiffs and the non-perferred hybridoric acid products and and Genviroldiffs are the non-perferred hybridoric acid products and products and produced the control of the contro	GELSTNs 3 thyslerinada sodiumi	GESSNE3 theatemate indiced	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	17320	GENVISC 850 - non-preferred	hyaluronan or derivitive	Ac of BRU/12022- HYALDAM, STAVICE, CHYINEC DHE, MITAURS, JAM TRUILPON will be the preferred hyplutionic add products and do not TRUILPON will be the preferred hyplutionic and products and do not Getling 3, Visco. 3, addium hyplutionic Priviles, Orthodous, Suparta FX, and GenVilles EX and the non-preferred hyplutionic acid products and prior authorization in required through the Plan Pharmacy Services. Rease use the Medical Policy for criteria	GENNIC 850 thyslumnan or decimbed	GENNES 850 Bysilvannain or derivihed	NAMO Prior Authorization based on National Coverage Determination (MCD), Local Coverage Determinations (ICDN), and Local Coverage Articles (ICAn) for guidance where applicable for Jurisdictions WI, II, MD
Medical	10223	GIVLAARI	givosiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Hematologist or specialist with expertise in diagnosis and management of AHP with authorization.	GIVIAARI (ghosiran)	SIVI.AARI (givosiran)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 7), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10257	GLASSIA	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to an Pulmonology specialist with authorization.	GLASSIA (Alpha-1-proteinase Inhibitor)	GLASSIA (Alpha-1-proteinase Inhibitor)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	11447	GRANIX	tbo-filgrastim	As of 01/01/2023: Nivestym and Zanxio are the preferred Filgrastim products and do not require prior authorization. Please see Medical Policy for criteria.	SRANIX (the-filgrastim)	GRANIX (the-figraxim)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy	17170	HEMLIBRA	emicizumab	Yes, through Navitus. Refer to members pharmacy benefit formulary for coverage.		HEMUSSA (emicirum ab)	
Medical	17170	HEMLIBRA	emicizumab	Yes, through the Plan Pharmacy Services	HEMLIBRA (emicizumab)	HEMI IBRA (emicirum ab)	Medicare coverage for outpastent (Part 8) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals.
Medical	19355	HERCEPTIN	trastuzumab injection	Herzuma and Trazimera are the preferred Trastusumab products and do not require prior authorization. Herceptic, Ogivir, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Hease see Medical Policy for criteria.	HERCEPTIN (tracturemals injection)	HERCEPTIN (tracturumah injection)	MAYO Rior Authorization needed audined in the Medicare Benefit Policy Manual (Puls 1801), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19356	HERCEPTIN HYLECTA	trastuzumab and hyaluronidase-oysk	Yes, through the Plan Pharmacy Services	HERCEPTIN HYLECTA (trastuzumah and hyaluronidase-oysk)	HERCEPTIN HYLECTA (trastuzumah and hyaluronidase oysk)	MARO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11411	HEMGENIX	etranacogene dezaparvovec-drib	Yes through the Plan Pharmacy Services	HEMGENIX (etranacogene dezaparvovec-drlb)	HEMGENIX (etranacogene dezaparvovec-drib)	MAYO Prior Authorization needed outlined in the Medicane Benefit Policy Manual (Pub. 100-1), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5113	HERZUMA	trastuzumab-pkrb	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Oglyri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	HERZUMA (trasturumah-pkrh)	HERZUMA (tractionimals-plets)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drags and Biologicals for drugs
Medical	11559	HIZENTRA (SCIG), IMMUNE GLOBULIN	immune globulin (hizentra)	Services. Please see Medical Policy for criteria. Yes, through the Plan Pharmacy Services	HIZENTRA (SCIG)	HIZENTRA (SCIG)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19294	HOSPIRA	pemetrexed	Yes, through the Plan Pharmacy Services	HOSPIBA (gemetrexed)	HOSPRA (pemetrexed)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
L		1	1			1	

	DeanHeath ian	IN.	ECTABLE MEDICINES	SEARCH TIPS:			
		This reference guide is a partial listin are covered, not covered, or not yet	ng of the most commonly prescribed drugs under the medical benefit reviewed and whether a prior authorization is required. For coverage ered, please complete the Exception to Coverage form found on the al submit to the Plan Pharmacy Services and for pharmacy submit to	This is a large document, but you can search quickly and easily by clicking on the	ne binocular icon on your toolbar. It will then display a search box for you		
	Updated: 05/01/2024	review of any drug listed as not cov Dean Health Plan website for medic	ered, please complete the Exception to Coverage form found on the al submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	to type in the name of drug you want to locate. If you do not know the correct the na	spelling, you can start your search by entering just the first few letters of ne		
Benefit		Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J7321	HYALGAN - preferred	hyalluronate or derivative	As of 88/DZ-2022: PHALGAN, SYNVISC, SYNVISC DISE, PHMOVIS, and TRILLIDON will be be preferred hypluronic acid products and do not require prior authorization. Monovisc, Durolane, Geli-One, Euflewa, Gelispira, Visco, 3 double hypluronist, Privisc, Orthovisc, Supartar FX, and GenifyricSSD are the non-preferred hypluronic acid products and prior authorization is required through the Plan Pharmacy Services. Rease see Medical Policy for criteria	HYALGAN Dyalumouhe or derivation).		MAPD Prior Authorisation based on National Coverage Determination (MCD), Local Coverage Determinations (ECDs), and Local Coverage Articles (ECAs) for guidance where applicable for Jurisdictions WI, R, MD.
Medical	J9351	HYCAMTIN	topotecan	IV dosage form does not require PA Oral dosage form requires PA - Restricted to Oncologists with authorization through the PIan Pharmacy Services.		HYCAMTIN (topotecan)	
Medical	17322	HYMOVIS - preferred	hyaluronan	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMIOVIS, and TRILLIAND MILE DE preferred hyblusomic acid products and do not require prot authorisotion. Motionoice, Durable, Gold-One, Eufleaux, Gelsyn-3, Visco-3, sodium hyblusomics. In Visco, Chroboxic, Suparta TX, and centrication and environistic and enviro	HMMACHES (Byglucosan)		MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO.
Medical	J1575	HYQVIA (SCIG), IMMUNE GLOBULIN	immune globulin (hyqvia)	Yes, through the Plan Pharmacy Services	HYOMA (SCIS)	HYOWA (SCIG).	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13245	LUMYA	tildrakizumab-siemn	Yes, through the Plan Pharmacy Services.	ILUMYA (Edrakirumab asmo)	ILUMYA (tildrakizumab-asmn)	MAVD hirar Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 33, 550 Drugs and Biologicals for drugs
Medical	19173	IMFINZI	durvalumab	Yes, through the Plan Pharmacy Services	IMFINZI (durvalumab)	IMFINZI (durvalumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19347	IMJUDO	tremelimumab-actl	Yes through the Plan Pharmacy Services	IMUDO (transfirmumab-acti).	IMB/DO (translimumsh-atti)	MAMO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 300-2), Chapter 15, §50 Drugs and Biologicals for drugs:
Medical	19325	IMLYGIC	talimogene laherparepvec	Yes, through the Plan Pharmacy Services	IMLYGIC (talimogene laherparepvec)	IMLYGIC (talimogene laherparepvec)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	11750	INFED - preferred	Iron dextran	As of 08/01/2022: VENOFER, INFED, FERRILECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. INFECTAFER, MONOFERRIC, TRIFFERC, and TREERIC AVMINI are the non-perferred parenteral line products and prior authorization is required through the Plan Pharmacy Services.	INSED (ir on destrus)		
Medical	Q5103	INFLECTRA - non-preferred	infliximab-dyyb	Yes, through the Plan Pharmacy Services after failed trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	INFLECTRA (Infliximate-dysta)	INFIECTRA (inflinimals dayls)	MAMO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	19198	INFUGEM	premixed gemcitabine in sodium chloride solution	Yes, through the Plan Pharmacy Services	INFUGEM (premised generatables in sodium chloride solution).	INFUGEM (premixed gericitatine in sodium chloride solution)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1439	INJECTAFER - non-preferred	ferric caroxymaltose	As of 08,701/2022: VENDERS, INFED, FERRILECT, and FERAHEIMS are the preferred parenteral iron products and do not require prior authorizations. INSECTAFER, MONOSPERS, TRIFFERS, and TREFRIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	INSECTAFER (Ferric caresymaltose)	SNECTAFER (foric caronymaltose)	NANO Prior Authorization needed socilized in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	A4359, E2103	Insulin Pumps (MAPD ONLY)		Yes, through Dean Health Plan Utilization Management Department. MAPD ONLY	INSULIN POMPS	INSTITUT PUMPS	
Medical	J1566	IVIG, IMMUNE GLOBULIN (GAMMAGARD S/D, CARIMUNE NF)	immune globulin, powder	Yes, through the Plan Pharmacy Services	SCIG (Immune Globulin)	SCIG thermore Globulin)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	11599	IVIG, IMMUNE GLOBULIN	immune globulin, liquid	Yes, through the Plan Pharmacy Services	tWG (tremune Globulin)	IVG (Immune Globulin)	MAPD Prior Authorization based on National Coverage Determination (NCD). Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	12782	IZERVAY	avacincaptad pegol	Yes, through the Plan Pharmacy Services	Itervsy''' (avedincastad segol)	Izence/** [avadin/aptail pegol]	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19281	JELMYTO	mitomycin	Yes, through the Plan Pharmacy Services	IELMYTQ (mitomycin)	IELMYTO (mitomycin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-7), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19272	JEMPERLI	dostarlimab	Yes, through the Plan Pharmacy Services	JEMPERLI (dostariimab-gdy)	JEMPERLI (dostariimab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19043	JEVTANA	cabazitaxel	Yes, through the Plan Pharmacy Services	JEVTANA (cabasitaxel)	JEVTANA (cabazitasel)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs.
Medical	13590	JUBBONTI	denosumab	EFFECTIVE 05/31/2024. Yes, through the Plan Pharmacy Services	IURROHII (Annoismab)	JUBBONTI (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	19354	KADCYLA	ado-trastuzumab emtansine	Yes, through the Plan Pharmacy Services	KADCYIA (ado-trastuzumab emtansine)	KADCYLA (ado-trastuzumab emtansine)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	11290	KALBITOR	Kalbitor (ecaliantide)	Yes, through the Plan Pharmacy Services	KALBITOR (ecallamide)	SAURITOR (contamble)	MARO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Picb. 100 2), Chapter 15, \$60 Drugs and Biologicals for drugs
Medical	Q5117	KANJINTI	trastuzumab-anns	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	EANUNTI (trastusumah-anna)	EANUNTI Eschelipase affal	MARD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 150-2), Chapter 15, \$60 Drugs and Biologicals for drugs
Medical	12840	KANUMA IV	sebelipase alfa	Yes, through the Plan Pharmacy Services	KANUMA IV (sebelirase alfa)	SANUMA IV (sebelipase-alfa)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	13490	Ketamine for Chronic Pain and Mental Health and Substance Related Disorders		None. Not Covered.	Ketamine for Chronic Pain and Mental Health and Substance Related_ Disorders		
Medical	19271	KEYTRUDA	pembrolizumab	Yes, through the Plan Pharmacy Services	KEYTRUDA (gembrolizumab)	SEYTRUDA (gembrolizumah)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19274	KIMMTRAK	tebentafusp-tebn	Yes, through the Plan Pharmacy Services	KIMMTRAK (tebentafusp-tebn)	s)MMTRAK (tebentafusp-tebn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12507	KRYSTEXXA	pegloticase	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Rheumatologist or Nephrologist specialist with authorization.	ERYSTEXXA (pegioticase).	SRYSTEXXA (pegloticase)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q2042	KYMRIAH	tisagenlecleucel	Yes, through the Plan Pharmacy Services	KYMRIAH (tisagenlerleucel)	EYMRIAH (Gsagenleckeucel)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19047	KYPROLIS	carlizomib	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	KYPROLIS (carfizomb)	EYPROLIS (carfizomib)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	10217	LAMZEDE	velmanase alfa-tycv	Yes, through the Plan Pharmacy Services	LAMZEDE (volmanase alfa-tycv)	SAMZEDE (volmanase alfa-tyco)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, \$50 Drags and Biologicals for drugs

DeanHeath 5	in IN	IJECTABLE MEDICINES	SEARCH TIPS:			
	This reference guide is a partial list are covered, not covered, or not ye	ting of the most commonly prescribed drugs under the medical benefit it reviewed and whether a prior authorization is required. For coverage overed, please complete the Exception to Coverage form found on the lical submit to the Plan Pharmacy Services and for pharmacy submit to	This is a large document, but you can search quickly and easily by dicking on t	the binocular icon on your toolbar. It will then display a search box for you		
	review of any drug listed as not co Dean Health Plan website for med	overed, please complete the Exception to Coverage form found on the lical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	the to type in the name of drug you want to locate. If you do not now the convex spalling, you can start your search by entering just the first few letters of the name.			
Updated: 05/01/2024 Benefit J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical J3490, C9399	LANREOTIDE	somatuline depot	Yes, through the Plan Pharmacy Services	LANREOTIDE (somatuline depot)	LANREOTIDE (somatuline depot)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical J3590	LANTIDRA	donislecel-jujn	Yes, through the Plan Pharmacy Services	LANTIDRA** (donistecel-jujn)	LANTIDRA™ (donislecel-jujn)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 1002), Chapter 15, §50 Drugs and Biologicals for drugs.
Medical J0202	LEMTRADA	alemtuzumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialist with authorization. Infusions must be administered at a facility certified for LEMTRADA infusions.	LEMTRADA (alemtuzumab)	JEMTRADA (alemturumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 1002), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical J0174	LEQEMBI	lecanemab-irmb	Yes, through the Plan Pharmacy Services	LEGEMBI** (lecanomab-irmb)	LEGEMBI** (Issanemab-irmb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical J1306	LEQVIO	Inclisiran	None. Not covered.	LEOVIO (inclisiran)		
Medical J0641, J0642	LEVOLEUCOVORIN	fusilev khapzory	Yes, through the Plan Pharmacy Services	LEVOLEUCOVORIN	<u>IEVOLEICOVORIN</u>	MAPD Price Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical J0650	N/A	Levothyroxine Injection (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Medical physician specialist with authorization.	LEVOTHYROXINE INJECTION (INTRAVENOUS)	LEVOTHYRODONE INJECTION (INTRAVENOUS)	
Medical J9119	LIBTAYO	cemiplimab	Yes, through the Plan Pharmacy Services	LISTAYO (comingilimath-rank)	USTAYO (cemiolimab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical J2001	LIDOCAINE FOR CHRONIC PAIN		None. Not Covered.	LIDOCAINE FOR CHRONIC PAIN		
Medical J9999	LOQTORZI	toripalimab-tpzi	Yes, through the Plan Pharmacy Services	LOOTOR2 (toripalimab-toxi)	LOQTORZi (toripalimab-tozi)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical J2778	LUCENTIS	ranibizumab	No. No prior authorization required	LUCENTIS (ranibinumab)		MAYO Price Authorization based on National Coverage Determination (PICD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for jurisdictions WI, II, MO
Medical J2778	LUCENTIS	ranibizumab	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Medical J0221	LUMIZYME	alglucosidase alfa (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Pompe DX with authorization.	LUMIZYME (alglucosidase atla) (intraremous).	LUMIZYME (alglurosid sie alfa) (intravenous)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical J9313	LUMOXITI	moxetumomab pasudotox	Yes, through the Plan Pharmacy Services	LUMOXTI (movetumomab pasudotox-tdfk)	LUMOVETI (movetumomab pasudotos)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical J9350	LUNSUMIO	mosunetuzumab-axgb	Yes, through the Plan Pharmacy Services.	LURSUMIO** (mosunetuzumab-axgb)	LUNSUMIO™ (mosunetuzumab-axeb)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical A9513	LUTATHERA	lutetium Lu 177 dotatate	Yes, through the Plan Pharmacy Services	LUTATHERA (Isotium tu 177)	LUTATHERA (lunetium Lu 177)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical J3398	LUXTURNA	voretigene neparvovec-rzyl	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a specialist who treats the retinal dystrophy with authorization.	LUXTURNA (voretigene neparvovec-rzyl)	LUXTURNA(voretigene neparvovec-ryzi)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical J3590	LYFGENIA	lovotibeglogene autoemcel	Yes, through the Plan Pharmacy Services	LYFGENIA (levelibeglogene autoemosi).	LYFGENIA (lovolibegiogene autoemsell)	
Medical J9353	MARGENZA	margetuximab	Yes, through the Plan Pharmacy Services	MARGENZA (margatuximab)	MARGENZA (marpetuximab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical J3397	MEPSEVII	vestronidase alfa-vjbk (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis VII with authorization.	MEPSEVII (vestronidase alfa-sitis) (intravenous)	MEPSEVILIvectronidase affe stibit (intravenous)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs:
Medical J9349	MONJUVI	tafasitamab-cxix	Yes, through the Plan Pharmacy Services	MONUVI (tafasitamab-cxix)	MONIUVI (tafasitamab-coix)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical J1437	MONOFERRIC - non-preferred	ferric derisomaltose	As of OR/DI/2022: VENOFER, INFED, FERRIECTT, and FERAHEME are the preferred parenteral iron products and do not require prior authorization. NIGCHEFER, MONDREWS, TREFREX, and TREFRIC AVNU are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	MONOFERRY: (Ferric derinomalitase)	MONOFFRIC Neric Arisomaticus	MAYO From Authorization needed outlined in the Medicare Benefit Pulsy Manual (Puls. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical J7327	MONOVISC - non-preferred	hyaluronan or derivative	As of 08(01/2002: HYALGAN, SYNVESC, SYNVESC DNE, HYMONS, and TRILLIRON will be the preferred hypatronic scid products and do not require prior authorization. Monoviec, Durolane, Gel-One, Euflewa, Geleyn-S, Visco-S, addimylaronate, Trivisc, Orthonic, Suparts PR, and GonVirleSGO are the non-preferred hybaronic acid products and prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	56/06/00/SC (hopkinning on derivative).	560NCN/SC (hyskeronian or derivativa).	MANO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Activities (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO.
Medical Q5107	MVASI	bevadzumab-awwb	As of 88/01/2004. Trisbev is the preferred Bevactumals product and does not require prior authorization. Availin, Aymoy, Minds and Vegarima prior authorization is required through the Plan Rhamasy Services. ***Prior authorization for bevactumals is not required when used for ophtralmological indication.*** See the ALTMSS (bevactumals) Policy for a list of applicable ophthalmological diagnoses.	MVASI (havoichumáli-awah).	MASS flevoritumsh-zeerbi	MAPD First Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for lurisdictions Wi, II, MD.
Medical J9203	MYLOTARG	gemtuzumab ozogamicin	Yes, through the Plan Pharmacy Services	MYLOTARG (gembuzumah ozogamicin)	MYLOTARG (gemtuzumab ozogamicin).	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical J0587	MYOBLOC	rimabotulinumtoxinB	No prior authorization is required.	MYOBLOC (rimabotulinamtoxinB)		MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MD.
Medical J1458	NAGLAZYME	galsulfase (intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis VI with authorization.	NAGLAZYME (galoutfase).	NAGLAZYME (galsulface).	MARD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical J2323	NATALIZUMAB	tysabri	Yes, through the Plan Pharmacy Services	NATALIZUMAB (Tysibhi: Tyroko)	NATAI(ZUMAB (Tycabri: Tyrnio)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical J2506	NEULASTA	pegfligrastim	EFFECTIVE 01/01/2024: FULPHILA and NYVEPRIA are the preferred Pegiliparatim products and do not require prior authorization. Must have a failed irrid of ZERTENZO MO FULPHILA before coverage of Neudata. UDENCYA, PUNETRA, STIMUFEND and ZERTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NEVRASTA (pepflipractim)	NEXASTA (negfligractim)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy J2506	NEULASTA	pegfilgrastim	Yes, Through Navitus	NEURASTA (pogfigrastim)	NEURASTA (pogfägrastim)	
Medical J1442	NEUPOGEN	filgrastim	EFFECTIVE 01/01/2023: Nivestym and Zanio are the preferred Filgrastim products and do not require prior authorization. Neupogen, Refeuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NEUPOGEN (Filgrassion)	NEUPOGEN (filprantim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical N/A	NEW TO MARKET MEDICAL PHARMACY PRODUCTS CURRENTLY UNDER CLINICAL REVIEW	New to Market Medical Pharmacy Products currently under clinical review	Policy regarding Medical Pharmacy products under current clinical review	NEW TO MARKET MEDICAL PHARMACY PRODUCTS CURBENTLY UNDER- CUNICAL BEVIEW.		
Medical N/A	NEW TO MARKET MEDICAL PHARMACY PRODUCTS	New to Market Medical Pharmacy Products	Policy regarding New to Market Medical Products	NEW TO MARKET MEDICAL PHARMACY PRODUCTS		
Medical J0219	NEXVIAZYME	avalglucosiidase alfa	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Pompe DX.	NEXMAZYME (avalphycosidase alfa)	NEXHAZYME (avalghyrosidase alfa)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs

	DeanHeath fan	IN	JECTABLE MEDICINES	SEARCH TIPS:			
		This reference guide is a partial listi are covered, not covered, or not yet	ng of the most commonly prescribed drugs under the medical benefit reviewed and whether a prior authorization is required. For coverage	This is a large document, but you can search quickly and easily by clicking on t	the binocular icon on your toolbar. It will then display a search box for you		
		review of any drug listed as not co- Dean Health Plan website for medi	ng of the most commonly prescribed drugs under the medical benefit reviewed and whether a prior authorization is required. For coverage wred, plasia complete the Exception to Coverage form found on the cal submit to the Han Pharmacy Services and for pharmacy submit to Navitus.	to type in the name of drug you want to locate. If you do not know the corre- the na	ct spelling, you can start your search by entering just the first few letters of me		
Benefit	Updated: 05/01/2024 J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
benem	7 couc	Diana Names	General manes	EFFECTIVE 01/01/2023: Nivestym and Zanxio are the preferred Filigrastim	roncy	THO AUTOLOGOT OTH	WHY U
Medical	Q5110	NIVESTYM	filgrastim-aafi	products and do not require prior authorization. Neupogen, Releuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	NVESTYM (figractim-aaft)	NIVESTYM (filgrastim-aafi)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 150-1), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	12796	NPLATE	romipostim	Yes, through the Plan Pharmacy Services	NPLATE (romipostim)	NPLATE (romipostim)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J2182	NUCALA	mepolizumab	Yes, through the Plan Pharmacy Services. Eosinophilic asthma: Restricted to Pulmonology, Allergy, and Immunology specialists with authorization. Eosinophilic granulomatoris with polyangitis (EGPA): Restricted to a Pulmonology, Immunology, Allergy or Rheumatology specialist with authorization.	NUCALA (megeli sumah).	NMCALA (megalizumah)	MAVD Prior Authorization needed outlined in the Medicare Benefit Pulling Manual (Pub. 100-3), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	J3490, C9399	NULIBRY	fosdenopterin	Yes, through the Plan Pharmacy Services. Restricted to a neurologist, medical geneticist, or a provider who specializes in management of inborn errors of metabolism with authorization.	NUISSY Rosdengsterin)	NJUBRY (foodenosterin)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pulb. 100 2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5122	NYVEPRIA	pegfligrastim-apgf	EFFECTIVE 01/01/2023: FULPHILA and ZIEXTENZO are the preferred Pegfill grastim products and do not require prior authorization. Must have a failed trial of ZIEXTENZO AND FULPHILA before coverage of Neulasts. UDENCYA, NYVEPRIA, PYLNETRA, and STIMUFEND require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	NYVEPRIA (pogligration-appl)	NYVEPRIA (pogfilgractim-appl)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, \$50 Orags and Biologicals for drugs
Medical	J2350	OCREVUS	ocrelizumab	Yes, through the Plan Pharmacy Services. Restricted to Neurology specialists with authorization.	OCREAIS (ocretizumab)	OCREVUS (oversouverse)	MAVO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1568	OCTAGAM (IVIG), IMMUNE GLOBULIN	immune globulin (octagam liquid)	Yes, through the Plan Pharmacy Services	OCTAGAM (IVIG)	OCTAGAM (MG)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, IL, MO
Medical	Q5114	OGIVRI	trastuzumab-dikst	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	OSIVRi firastrumah-skut)	OGIVN (tractuumik-diet)	MAVO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Puls. 150 1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	OMISIRGE	omidubicel-only	Yes, through the Plan Pharmacy Services	CMSHGE* tomidulical-onlyl.	DMISIRGE* Comidulatest-on bit.	MAVO Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Puls, 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	C9168	омуон	mirikizumab-mrkz	Yes, through the Plan Pharmacy Services	OMNOM (mirikiyumab-mrka)	DMVOH (mirikizomab-mrkz)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 T), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19205	ONIVYDE	irinotecan liposome injection	Yes, through the Plan Pharmacy Services	ONIVYDE (irinotecan liposome injection)	ONIVIDE (irinotecan liposome injection)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10222	ONPATTRO	patisiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Oncology, Hematology or Neurology specialist with authorization.	CNPATTRO (natisiran)	ONPATTRO (estisican)	MATO Prior Authorization needled outlined in the Medicare Benefit Policy Manual (Pub. 100-10, Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q5112	ONTRUZANT	trastuzumab-dttb	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Oglyri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	QNTRUZANT (trastusumais-dttb)	ONTRUZANT (trastusumah-strib)	MAVO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Puls, 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19299	OPDIVO	nivolumab	Yes, through the Plan Pharmacy Services	OPDIYO (nivolumab)	0PD0/0 (rivolumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19298	OPDUALAG	nivolumab/relatlimab-mbw	Yes, through the Plan Pharmacy Services	OPDUALAG (nivolumats/relatilmats-rmbw)	OPDUALAG (nivolumab/relatlimab-rmbw)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	10129	ORENCIA (IV)	abatacept	Yes, through the Plan Pharmacy Services. Restricted to an Rheumatology specialist with authorization.	ORENCIA IV (abatacept).	ORENCIA IV (abatacept)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy	10129	ORENCIA (SC)	abatacept	Yes, through Navitus. Restricted to an Rheumatology specialist with authorization.	ORENCIA SC (abatacept)	ORENCIA SC (abatacept)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	17324	ORTHOVISC - non-preferred	hyaluronan or derivative	As of 08,012/002: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLINGN will be the preferred hyallomic acid products and do not require prior achidration. Monoisce, Lundraus, Gel One, Eufenau, Son Grant (1998), and the conjunction of the co	CATHORNIC (healtures as an distribution)	CRTHICHES (Businessan or discharbles)	MAPD Prior Authorisation based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictors WI, II, MD
Medical	10224	OXLUMO	lumasiran	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Nephrologist or Urologist specialist with authorization.	OXLUMO (humasiran)	OXLUMO (lumasiran)	MAVO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19259	PACLITAXEL PROTEIN-BOUND PARTICLES		Yes, through the Plan Pharmacy Services.	PACITAXEL PROTEIN-BOUND PARTICLES	PACITAXEL PROTEIN-BOUND PARTICLES	MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, IMO
Medical	19177	PADCEV	enfortumab vedotin-ejfv	Yes, through the Plan Pharmacy Services	PADCEV (enfortumab vendotin-ejfv)	PADCEV (enfortumab-vedotin-e)fv)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	10208	PEDMARK	soodium thiosulfate	Yes, through the Plan Pharmacy Services	PEDMARK* (sodium thiosulfate)	PEDMARK® (sodium thiosulfate).	MAVD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Puls. 2002), Chapter 15, \$60 Drugs and Biologicals for drugs
Medical	19304	PEMFEXY	pemetrexed	Yes, through the Plan Pharmacy Services	PEMFEXY (pametrexed)	PEMFEXY (permetrewed)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
	19247	PEPAXTO	(melphalan flufenamide	Yes, through the Plan Pharmacy Services	PEPAXTO* (melehalan flufonamide)	PEPAXTO* (molphalan flufenamide).	MAYO Prior Authorization needed outlined in the Madicare Benefit Policy Manual (Pub. 100-12, Chapter 13, 500 Drugs and Biologicals for drups
Medical	19306	PERJETA	pertuzumab	Yes, through the Plan Pharmacy Services	PERIETA (perturumab)	PERIETA (pertuzumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19316	PHESGO	pertuzumab, trastuzumab, hyaluronidase	Yes, through the Plan Pharmacy Services	PHESGO (perturumab)	PHESGO (parturumab)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	A9699	PLUVICTO	lutetium Lu 177 vipivotide tetraxetan	Yes, through the Plan Pharmacy Services	PLUMCTO flutetium Lu-177 viginotide tetravetan)	PLUVICTO flutetium Lu 177 vipivofide tetravetan)	MAYD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19309	POLIVY	polatuzumab vedotin-pliq	Yes, through the Plan Pharmacy Services	FOLIVY (polatuzumab vedotin-piis)	POLIVY (polatuzumab vedotin-pila)	MAPD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1203	POMBILITI	cipaglucosidase alfa-atga	Yes, through the Plan Pharmacy Services	POMBILITI (cipaglucosidase alfa-anga)	POMBILITI (cipaglucosidase alfa-atga)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19295	PORTRAZZA	necitumumab	Yes, through the Plan Pharmacy Services	PORTRAZZA (necitumumah)	PORTRAZZA (nechumumah)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	19204	POTELIGEO	mogamulizumab-kpkc)	Yes, through the Plan Pharmacy Services	POTELIGEO (mogamulitumab-lepkc)	POTEUGEO (mogamulizumab-kpkc)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1459	PRIVIGEN (IVIG), IMMUNE GLOBULIN	immune globulin	Yes, through the Plan Pharmacy Services	PRIVIGEN (IVIG)	PRIVIGEN (IVIG)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for jurisdictions Wi, II, MO.
Pharmacy	J0885, Q4082	PRDCRIT - non-preferred	epoetin alfa, (for non-esrd use)	Yes, through Navitus. Restricted to (in at least consultation with) a Oncology, Infectious Disease, Hematology, or Nephrology specialist with authorization.		PROCRIT (epostin alpha)	
				As of 01/01/2023: Retacrit is the preferred Epoetin Alfa products and			

	DeanHeath Fan	INJ	ECTABLE MEDICINES				
		This reference guide is a partial listing	g of the most commonly prescribed drugs under the medical benefit reviewed and whether a prior authorization is required. For coverage	SEARCH TUPS: This is a large document but you can search multible and easily by diction on the	he hinnrular iron on wour trollhar. It will then disnlay a search how for you		
		review of any drug listed as not cow	ered, please complete the Exception to Coverage form found on the al submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	he to type in the name of drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of			
Benefit	Updated: 05/01/2024	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medical	J9015	PROLEUKIN	aldesleukin	Yes, through the Plan Pharmacy Services	PROLEURN (aldeslaukin)	PROLEURIN (aldesleukin)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10897	PROLIA	denosumab	Yes, through the Plan Pharmacy Services. Restricted to (at least in consultation with) a Oncology, Rheumatology, Internal Medicine, Family Medicine, Orthopedic Surgery, or Endocrinology specialist with authorization.	PBOUA (denosumab).	280UA (denosumab).	MAPO Fror Authorization based on National Coverage Determination (PCD), Local Coverage Determinations (LCDs), and Local Coverage Antides (LCAs) for guidance where applicable for Jurisdictions, W. II., MO
Medical	Q2043	PROVENGE	sipuleucel-T	Yes, through the Plan Pharmacy Services	PROVENGE (signileusel-T)	PROVENGE (sign/eucel-T)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	J1304	QALSODY	tofersen	Yes, through the Plan Pharmacy Services	QALSODY** (tofersen)	OAISODY** (tofersen)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1301	RADICAVA	edaravone	Yes, through the Plan Pharmacy Services. Restricted to an Neurology specialist with authorization.	BADICAVA (edaravone)	BADICAVA (edaravone)	MMFO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	10896	REBLOZYL	lusptercept	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Oncologist specialist with authorization.	REBLOZYI (Iuspatercept-aamt)	BEBLOZYI, (luspatercept-aanst)	MAPD Prior Authorisation needed cullined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	Q5125	RELEUKO	filgrastim-ayow	EFFECTIVE 01/01/2023: Nivestym and Zarxio are the preferred Filgrastim products and do not require prior authorization. Neupogen, Releuko and Granis, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	RÉLEUXO (filgrastim-ayow)	RELEUKO (filgrastim-ayow)	MAPD Prior Authorization needed outlined in the Medicane Benefit Policy Manual (Plub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J1745	REMICADE - non-preferred	infliximab	Yes, through the Plan Pharmacy Services after failed trial of RENFLEXIS. Restricted to a Dermatology, Rheumatology, or Gastroenterology specialist with authorization.	REMICADE (infliximab)	SEMICADE (inflinemab)	MAVD Prior Authorisation based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for lurisdictions WI, II, IMD.
Medical	13285	REMODULIN IV	treprostinill	Generic Treprostinii will be covered with prior Authorization through the Plan Pharmacy Services. Brand REMODULIN will not be covered. Restricted to (in at least consultation with) a Cardiology or Pulmonology specialists with authorization.	RE MODULIN IV (treprostinil)	SEMODULIN IV (treprostniii)	MAVD Prior Authoritation needed outlined in the Medicane Benefit Policy Manual (Plub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q5104	RENFLEXIS - preferred infliximab product	infliximab-abda	As of 10/01/2019: Prior authorization for the preferred inflisimab product will only require provider attestation to an appropriate indication through the Plan Pharmacy Services.	RENGLEXIS (inflicionals-abda)	BENELEYS Sellivinsub-abdal	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO.
Pharmacy	Q5105	RETACRIT - preferred	epoetin alfa-epbx	Yes, through Navitus: Restricted to (in at least consultation with) a Oncology, infectious Disease, Hematology, or Nephrology specialist with authorization.	RETACRIT (spostin alfa-spbs)	SETACRIT (epostin alfa-sphs)	
Medical	Q5106	RETACRIT	epoetin alfa-eptix	As of 01/01/2023: Retacrit is the preferred Epoetin Alfa products and does not require prior authorization. Epogen and Procrit prior authorization is required through the Plan Pharmacy Services. Please see Medical Policy for criteria.	BETACRIT (epostin alfa-ephs)	BETACRIT (sportin alfa-sphr)	MAMO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions W, II, MO
Medical	17311	RETISERT	fluocinolone acetonide intravitreal implant	None. Not Covered.	RETISERT (fluocinolone acetonide intravitreal implant)		
Medical	13590	RETHYMIC	allogeneic processed thymus tissue-agdc)	Yes, through the Plan Pharmacy Services	RETHYMIC (Allogenic processed thymus tissue-agdc)	RETHYMIC (Allogenic processed thymus tissue-agdc)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.2), Chapter 15, \$50 Drugs and Biologicals
Medical	J3590, C9399	REVCOVI	elapegademase-lvtr	Yes, through the Plan Pharmacy Services	REVCOVI® (elapogadomase-hir).	SEVCOVI* (elapseademase-lvir).	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals
Pharmacy		RHOPRESSA	netarsudil	PHARMACY BENEFIT ONLY. Yes, through Navitus.	BHOPRESSA (notarsudif)	BHOPRESSA (netaroudit)	
Medical	Q5123	RIABNI	ritusimab-arnx	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of Ruxience or Truxima. Please see Medical Policy for criteria	89ABNI feltusimah-arral	BIARNI (ritusimab-arna)	MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO
Medical	13490	RIVFLOZA	nedosiran	Yes, through the Plan Pharmacy Services	SOVE OZA (nedosiran).	BIVE-GZA (needosiran).	MAVD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J9312	RITLIXAN	rituximab	Yes, through the Plan Pharmacy Services requiring a failed trial or contraindication of Rusience or Truxima. Please see Medical Policy for criteria	BITLICAN (riturimab)	RITLISAN (riturimah)	MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, II, MO
Medical	19311	RITLIXAN HYCELA	rituximab and hyaluronidase human	Yes, through the Plan Pharmacy Services	RETUXAN HYCELA (riturimab and hyaluronidase human)	SITUKAN HYCELA frituximab and hyaluronidase human)	MAPO Prior Authoritation based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCA) for guidance where applicable for furnishctions Wi, IL, MO
Medical	J9312	RITUXIMAB IV	rituxan, truxima, ruxiencem riabni	Yes, through the Plan Pharmacy Services	BITLIUMAB IV frituxan, truxima, ruxience, riabniò	SITLEUMAB IV (ritusan, trusima, rusience, riabni)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
Medical	11412	ROCTAVIAN	valoctocogene roxaparvovec-rvox	Yes, through the Plan Pharmacy Services	NOCTAVIAN® (valoctorogene roxaparvoves-next)	EOCTAVIAN® (valoctorogene roxaparvovec-rvox)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	11449	ROLVEDON	eflapegrastim-xnst	Yes, through the Plan Pharmacy Services	80LVEDON™ (oflapograstim-xnst)	BOLVEOON*** (effapegrastim-xnot)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	11449	ROLVEDON	elfapegrastim-xnst	EFFECTIVE 06/28/2024. Yes, through the Plan Pharmacy Services As of 01/01/2023: Rusience and Trusima are the preferred Rituximab	Coming Spoon	Coming Soon	MAPO Prior Authoritzation needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5119	RUXIENCE	rituximab-pvvr	products and does not require prior authorization. Riabni and Rituxan prior authorization is required. Please see medical policy for criteria	SOLICE (vitusimab-prec)	BLUNENCE (ritusimals-greet)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, IMD.
Medical	19061	RYBREVANT	amivantamab-vmjw	Yes, through the Plan Pharmacy Services	EYBREVANT (amivantamb-smint)	EYBREVANT (aminantamb-smiss)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 300 2), Chapter 15, 550 Drugs and Biologicals for drugs.
Medical	12998	RYPLAZIM	plasminogen, human-tvmh	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a medical Hematologist or MD specializing in plasminogen deficiency (PLGD) with authorization.	SYPIA7IM (stasminogen. human.tomb)	EYPLAZIM(plasminages, human-tymh)	MAVD Prior Authorization needed outlined in the Medicane Benefit Policy Manual (Plub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19333	RYSTIGGO	rozanolixizumab-noli	Yes, through the Plan Pharmacy Services	RYSTIGGO* (rozanolxizumab-nol.)	eySTIGGO* (rezanelwizumab-noll)	MAPO Prior Authorization needed cullined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	13590	RYZNEUTA	efbemalenograstim alfa-vuxw	Yes, through the Plan Pharmacy Services	RYZNEUTA (ofbemaknograstim alfa-vurse)	EYZNEUTA (efbemalenograssim alfa-vurw)	
Medical	13590	RYZNEUTA	efbemalenograstim alfa-vuxw	EFFECTIVE 06/28/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Soon	
Pharmacy		SANDOSTATIN	actreotide	Yes, through Navitus. Restricted to (in at least consultation with) a Endocrinologist, Oncologist, or Gastroenterologist specialist with authorization.	SANDOSTATIN (extreodid)		
Medical	12353	SANDOSTATIN LAR	octreotide suspension	Yes, through the Plan Pharmacy Services	SANDOSTATIN (octreotide suspension)	SANDOSTATIN (octreotide)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Rub. 100 F), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J2354	SANDOSTATIN	octreotide suspension (non-Depot Form)	Yes, through the Plan Pharmacy Services	SANDOSTATIN foctreodide suspension non depot form)	SANDOSTATIN foctreotide suspension (non-depot form)	
Medical	19064	SANDOZ	pemetrexed	Yes, through the Plan Pharmacy Services	SANDOZ (pemetrexed)	SANDOZ (pemetrexed)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs

		DeanHeath ian	INJ	IECTABLE MEDICINES				
		Updated: 05/01/2024	review of any drug listed as not cow	ng of the most commonly prescribed drugs under the medical benefit the revolved and whether a prior authorization is required. For coverage erred, please complete the Exception to Coverage form found on the all submit to the PKI an Pharmacy Services and for pharmacy submit to Navitus.	SEARCH TIPS: This is a large document, but your can search quickly and easily by clicking on to type in the name of drug you want to locate. If you do not know the correct the name of t	spelling, you can start your search by entering just the first few letters of		
Bene	fit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
Medica			SAPHNELO	anifrolumab-finia	Yes, through the Plan Pharmacy Services. Restricted to (in at least	SAPHNELO (anifrolumab-fnia)	SAPHNELD (anifrolumab-fnia)	MAYO Prior Authorization needed outlined in the Medicare Benefit holicy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medica			SARCLISA	isatuvimab-irfc	consultation with) a Rheumatology specialist with authorization. Yes, through the Plan Pharmacy Services	AND THE CONTRACTOR OF T	SARCUSA (saturimab-ife)	MAVD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 1), Chapter 15, \$50 Drugs and Biologicals for drugs
Medica	,,,,,		SARLUSA	Isatumnati-inc	Yes, through the Plan Pharmacy Services. Restricted to (in at least	Antonia (militaria de la companio del companio de la companio de la companio del companio de la companio del la companio del la companio de la companio del la companio del la companio de la companio de la companio de la companio de la companio del	Acceptant Commission on 17	washo, sura version resonan nominan in musarans, a essent sont Numerican room? Freshess 17 35 and 80 was a profilmen on units.
Medica	J7352	2	SCENESSE	afamelanotide	consultation with) a Dermatologist, Medical Geneticist, or a Physician specializing in the treatment of cutaneous porphyrias with authorization.	SCENESSE (aflamelanotide)	SCENESSE (afamelianotide)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
	N/A		SELF-ADMINISTERED DRUG LIST		PHARMACY BENEFIT ONLY. Verify prior authorization requirements by accessing the members formulary.	SELF-ADMINISTERED DRUG LIST		
Medica	J2502	2	SIGNIFOR LAR	pasireotide	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist specialist with authorization.	SIGNIFOR LAR (pasireortide)	SIGNFORLAR(pasireortide)	MAVD fror Authorization needed outlined in the Medicare Benefit Pulicy Manual (Pub. 100-3), Chapter 15, \$50 Drugs and Biologicals for drugs
Medica	J1602	2	SIMPONI ARIA	golimumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthritis, Peripheral Anklysionis Spondyllis, or Pointata Arthritis) or Gastroenterology specialist with authorization.	SIMPONE ARIA (golimumab)	SIMPONI ARIA (golimumab)	MAVD Pror Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 150.2), Chapter 15, 540 Drugs and Biologicals for drugs
Pharma	ry J1602	2	SIMPONI ARIA	golimumab	Yes, through Navitus. Restricted to (in at least consultation with) an Rheumatology (Rheumatoid Arthritis, Peripheral Ankylosing Spondylitis, or Psoriatic Arthritis) or Gastroenterology specialist with authorization.	SIMPONI ARIA (polimumab)	SIMPONI ARIA (polimumab):	MAVD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Puls. 100.2), Chapter 15, 550 Drugs and Biologicals for drugs
Medica			SITE OF SERVICE		Yes, through the Plan Pharmacy Services. Requests for select specialty drugs as listed in the list in section 'Orugs in Scope' to be administreed in a hospital outpatient setting may be directed to a preferred alternative site of care, such as home infusion provider or a physician office.	SITE OF SERVICE		
Medica	J3590	0	SKYSONA	elivaldogene autotemcel	Yes, through the Plan Pharmacy Services	SKYSONA* felivalidogene autotemcell.	SEYSONA* felivaldogene autotemcell.	MAVD Prior Authoritation needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medica	J2327	7	SKYRIZI IV	risankizumab	Yes, through Plan Pharmacy Services. Restricted to Gastroenterologiy specialist with authorization.	SKYRIZI IV (risankirumah IV).	SEVE(Z) IV (risankizumah IV)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Medica	J1300	D	SOLIRIS	eculizumab	Yes, through the Plan Pharmacy Services. Restricted to a Neurologist or Nuero-Opthalmonogist, Nephrology, Hematology, Oncology, or Transplant specialist with authorization.	SOURIS (orolizomab)	SOURIS Facelizumāb)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (ICDs), and Local Coverage Articles (ICAs) for guidance where applicable for suridictions WI, II, MO
Medica	J1930	0	SOMATULINE	lanreotide depot	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Endocrinologist, Oncologist, or gastroenterologist specialist with authorization.	SOMATUUNE flarrentide-denoti	SOMATULINE flarreotide-depot)	MAND Prior Authorization needed cutlined in the Medicare Benefit Pulsy Manual (Pub. 100-3), Chapter 15, 560 Drugs and Biologicals for drugs
Medica	11747	7	SPEVIGO	spesolimab	Yes, through the Plan Pharmacy Services	SPEVIGO* (spesolimab)	SPEVIGO® (spesolimab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medica	12326	5	SPINRAZA	nusinersen	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an Neurology specialist with expertise in SMA treatment with authorization.	SPNR67A (mulmersen)	SPINEAZA (musinersen)	MAVD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Puls. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medica	J3490	0	SPRAVATO	esketamine	Yes, through the Plan Pharmacy Services	SPRAVATO* (esketamine)	SPRAVATO* (esketamine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, \$50 Drugs and Biologicals for drugs
Medica	J3358	8	STELARA (IV)	ustekinumab	Yes, through the Plan Pharmacy Services. Restricted to an Gastroenterology specialist with authorization.	STELARA IV fustekinumabb	STELARA IV fostokinomabi	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Puls. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharma	cy J3358	В	STELARA (SC)	ustekinumab	Yes, through Navitus. Restricted to an Gastroenterology specialist with authorization.	STELARA SC (ustekinumab)	STELARA SC (ustekinumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medica	13590	D	STIMUFEND	pegfilgrastim-pbbk	EFFECTIVE DJ/DJ/2024: FLUPHILA and NYVEPRIA are the preferred Pegflignastim products and do not require prior authorization. Must have a failed trial of ZEXTERZO AND FLUPHILA before coverage of Neulasta. UDENCYA, PYLNETRA, STIMUFEND and ZEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	STIMUFEND (negfigrantim-obbid)	STIMUFFRO feogfigrantim-obbbl	MAPD Price Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.7), Chapter 15, \$50 Drugs and Biologicals for drugs
Pharma	cy		Sublingual Immunotherapy (SLIT) for ALLERGY products	GRASTEK (Timothy grass pollen allergen extract), RAGWITEK (Short ragweed pollen allergen extract), ORALAIR (Sweet Vernal, Orbrade, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens allergen extract), ODACTRA (House Dust Mite allergen extractt)	Yes, through Navitus. Must be prescribed by an allergist, immunologist, or physician with active and orgoing experience in the diagnosis and treatment of allergic disease and use of immunotherapy products with authorization	SLIT for Allergy Products	SLIT for Allergy Products	
Medica	17321	1	SUPARTZ FX - non-preferred	hyaluronan or derivative	As of OB(01/2022- HYALGAN, SYNYISC, SYNYISC CINE, HYMIOVIS, and TRILLIKON will be the performed hyalutonic acid products and do not require prior architectation. Microsiscy, furnising, Get-One, Euriferas, Geliero S. Vicenza, Santonia, Microsiscy, Grandian, Geliero S. Vicenza, Germania, Geliero S. Vicenza, Germania,	5.EPARTZ EX (hoshiosolae de derivation)	SLEPARTZ EX (hoskinssion on derivation)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD
Medica	J1627	7	SUSTOL	granisetron extended-release	Yes, through the Plan Pharmacy Services	SUSTOL (granisetron extended-release)	SUSTOL (granisetron extended-release)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medica	J2781	1	SYFOVRE	pegcetacoplan	No prior authorization is required. Please see medical policy criteria	SYFOvRE™ (pegcetacopian)		MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medica	J2860	0	SYLVANT	siltuximab	Yes, through the Plan Pharmacy Services	SYLVANT (situaimab)	SYLVANT (citusimah)	MAYO Price Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biological for drugs
Medica	90371	8	SYNAGIS	palivizumab	Yes, through the Plan Pharmacy Services. Restricted to NICU Physician, Neonatologist, or Pediatric specialist (including family practice, general pediatrics, pediatric pulmonology, and pediatric cardiology) with authorization.	SYNAGIS (palivizumab)	SYNAGIS (palivizumab).	
Medica	17325	5	SYNVISC - preferred	hyaluronan or derivative	As of 08/01/2022 HYALGAN, SYNVISC, SYNVISC ONE, HYALOVS, and TRILLINON will be the preferred hybrium is cost products and do not require plot architectation. Moreovisc, Studiens, Gel Crist, Echiense, and Gel William and the operation hybrium cost of products and and Gelliviscisis and more perferred hybrium cost products and prior authorization is required through the Plan PRanmary Services. Resease see Medical Policy for criteria	SSNMSG (tresharense or derhallos)		MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medica	J7325	5	SYNVISC ONE - proferred	hyaluronan or derivative	As of 8.06.1/2022 HYALGAN, SYNYCE, SYNYCE CHE, PRODUCE, and BILLIURDN will be the preferred hyphonics and products and do not REMILIORN will be the preferred hyphonic products and do not reason to the state of the state of the state of the state of the Gellyn 3, Visco 4, addism hyphonic products and Gellyn 2, Visco 4, addism hyphonic paid products and prior authorization in required through the Plan Pharmacy Services. Rease see Medical Policy for orders	SCHOOL COSE Structurement or declarities		MATO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MD

	DeanHeath far	IN	IJECTABLE MEDICINES				
			ing of the most commonly prescribed drugs under the medical benefit t reviewed and whether a prior authorization is required. For coverage	SEARCH TIPS: This is a large document, but you can search quickly and easily by dicking on to	the binocular icon on your toolbar. It will then display a search box for you		
		review of any drug listed as not co Dean Health Plan website for medi	overed, please complete the Exception to Coverage form found on the ical submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	to type in the name of drug you want to locate. If you do not know the correct the na	t spelling, you can start your search by entering just the first few letters of		
Benefit	Updated: 05/01/2024 J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	маро
Medical	13055	TALVEY	talquetamab-tgvs	Yes, through the Plan Pharmacy Serices	TALVEY** (talquetamab-tps)	TALVEY** (talquotamab-tpvs)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	Q2053	TECARTUS	brexucabtagene autoleucel	Yes, through the Plan Pharmacy Services	TECARTUS (brevucabtagene autoleucel)	TECARTUS (brexucabtagene autoleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19022	TECENTRIQ	atezolizumab	Yes, through the Plan Pharmacy Services	TECENTRIQ (atezelizumab)	TECENTRIQ (atezolizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Puls. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	C9148	TECVAYLI	teclistamab-cqyv	Yes through the Plan Pharmacy Services	TECVANU (terlistamab-covv)	TECVAYU (teclistamab-covs).	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3241	TEPEZZA	teprotumumab-trbw	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Ophthalmologist and Endocrinologist specialist with authorization.	TEPEZZA (teprotumumab-trbw)	TEPEZZA (teprotumumab-trbw)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19314	TEVA	pemetrexed	Yes, through the Plan Pharmacy Services	TEVA (parmetriosed)	TEVA (gametrored)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J2356	TEZSPIRE	tezepelumab	Yes, through the Plan Pharmacy Services	TEZSPIRE (tezepelumab)	TEZSPIRE (toprotumumab-trbw)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19273	TIVDAK	tisotumab vedotin-tftv)	Yes, through the Plan Pharmacy Services	TIVDAK (tisotumah vedotin-tifty).	TIVDAK (tisotumah vedotin-titv)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5133	TOFIDENCE	tocilizumab-bavi	Yes, through the Plan Pharmacy Services	TOFIDENCE (toritiumab-bavi)	TORDENCE (tocilizumab-barri)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q5116	TRAZIMERA	trastuzumab-qyyp	Herzuma and Trazimera are the preferred Trastuzumab products and do not require prior authorization. Herceptin, Ogivri, Kanjinti and Ontruzant, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	TRAZIMERA (trastuzumab-gyyp)	TRAZIMERA (trastuzumab-gago)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19033	TREANDA	bendamustine	Yes, through the Plan Pharmacy Services	TREANDA (bendamustine)	TREANDA (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J7332	TRILLIRON - preferred	sodium hyaluronate	As of DR/D1/2022-HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLIADN will be the preferred hyaluronic acid products and do not require prior authorisation. Monovisc, Durolance, Gel-Ine, Eufleway, Goldyon, Sylvisco 3, dodium hyaluronate, Trifvisc, Orthovisc, Supartz FX, and GenVirscSS are the non-preferred hyaluronic acid products and prior authorization is required through the Plan Pharmacy Services	ZBILLHON foodsum hyslutnostad		MANO Prior Authorization based on National Coverage Determination (MCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCA) for guidance where applicable for Jurisdictions WI, II, MD
Medical	17329	TRIVISC - non-preferred	hyaluronan or derivative	As of 08/01/2022: HYALGAN, SYNVISC, SYNVISC ONE, HYMOVIS, and TRILLINON will be the preferred hybluronic acid products and do not require prior subricoston. Monovisc, Unablace, Gel-One, Euflenax, Gelipha, 3, Waso-3, sodium hyblianosate, IfVisic, Orthonics, Superit TX, and Gentiviscost and the non-preferred hybranics acid products and prior authorities on required through the Plan Pharmacy Service. Received the Plan Pharmacy Service.	120/05C Organization on decinalizati	20005. Brokeronen er derhedisch	MAYO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCNs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	19317	TRODELVY	sacituzumab govitecan-hziy	Yes, through the Plan Pharmacy Services	TRODELYY (sariturumah poviteran-hziy)	TRODELVY (sacituzumah govitecran-húy)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1746	TROGARZO	ibalizumab	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an infectious Disease specialist with authorization.	TROGARZO (ibalizumab)	TROGARZO (ibalizumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q5115	TRUXIMA	ritusimab-abbs	As of 01/01/2023: Rusience and Trusima are the preferred Ritusimab products and does not require prior authorization. Riabni and Ritusan prior authorization is required. Please see medical policy for criteria	TBROMA (clusimals-abbs).	TRUOMA (otusimals-abbs).	MAPD Fror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	Q5134	TYRUKO	natalizumab	Yes, though the Plan Pharmacy Services	TYRUKO (natalisumab)	TY8080 (natalizumah)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	12323	TYSABRI	natalizumab	Yes, through the Plan Pharmacy Services. Restricted to a Neurology or Gastroenterology specialist with authorization.	TYSABRI (natalizumab)	TYSABRI (natalizumab)	MMO Prior Authorization needed cutlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter \$5, \$500 Drugs and Biologicals for drugs
Medical	C9149	TZIELD	teplizumab-mzwv	Yes through the Plan Pharmacy Services	TZELD (topizumab-mzwz)	TOELD (tepizumab-mzwy)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q5111	UDENYCA	pegfligrastim-cbqv	EFFECTIVE D3/01/2024: FULPHILA and MYVEPRIA are the preferred Pegility partiting products and do not require prior authorization. Must have a failed trial of ZIENTEND AND FULPHILA before coverage of Neulasta. UDENCYA, FYLNETRA, STIMUFEND and ZIEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	LIDENCYA (pegfisgractim-cbcq)	LDENCYA (psyllagratim cbgv)	MAYD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 1002), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1303	ULTOMIRIS	demusiluvar	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Hematology, Oncology, or Immunology specialist with authorization.	INTOArikis (ravolizumah)	JR.TOAMHS Frauditumabb	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J1823	UPLIZNA	inebilizumab-cdon	Yes, through the Plan Pharmacy Services	UPLIZNA® (inetritiumab-cdon)	UPUZNA* (inebilizumab-cdon)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 1002), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	18499	UPTRAVI-IV	selexipag	Yes, though the Plan Pharmacy Services. Restricted to (in at aleast consultation with) a cardiologist or pulmonologist with authorization.	LIPTRAVI-IV (selexipag)	UPTRAVI-IV (selecipag)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Pharmacy		UPTRAVI	selexipag	Yes, though Navitus. Restricted to (in at aleast consultation with) a cardiologist or pulmonologist with authorization.	LPTRAVI Selectionel	UPTRAVI (selecina)	
Medical	12777	VABYSMO	faricimab-svoa	No. No prior authorization required	WARYSMO** (faricimab-svoa)		MAPD Fror Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (UCD), and Local Coverage Articles (UCA) for guidance where applicable for Jurisdictions Wi, II, MO
Medical	12777	VABYSMO	faricimab-svoa	EFFECTIVE 07/01/2024. Yes, through the Plan Pharmacy Services	Coming Soon	Coming Spon	MAPO From Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (NCD), Local Coverage Action (NCD), and Local Coverage Actions (NCA) for guidance where applicable for Jurisdictions WI, II, MO
Medical	19303	VECTIBIX	panitumumab	Yes, through the Plan Pharmacy Services	<u>veCtiBix (ganitumumab)</u>	<u>VECTIBIX (garitumumab)</u>	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19041	VELCADE	bortezomib - preferred	Yes, through the Plan Pharmacy Services	VELCADE (bortezomib)	VELCADE (bortezomib)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	Q5129	VEGZELMA	bevacizumab-adcd	As of 03/01/2024: Zirabev is the preferred Bevacisiumub product and does not require prior authorization. Avastin, Alymays, Nivosi and Vogestima prior authorization is required through the Plan Phamacy Services. ""Prior authorization for bevacisiumub is not required when used for ophationilogical indications." See the ALYMSY (bevacisiumub) Policy for a list of applicable ophthalmological disensories.	1850ZLIMA Decadinemsk adedl	SECSTIMA (Ispozito-mak) adodi	MMO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for jurisdictions WI, II, MO
Medical	J1756	VENOFER - preferred	Iron sucrose	As of 08/01 2022: VENOFER, INFED, FERRLECT, and FERAHEME are the preferred parenteral iron products and do not require prior authorizations. INSECTAFER, MONOTERE, TRIFFERC, and TRIFERIC AVNUI are the non-preferred parenteral iron products and prior authorization is required through the Plan Pharmacy Services with authorization.	SENOFER from surrose).		

	DeanHeath ion	IN	IECTABLE MEDICINES				
		This reference guide is a partial listin are covered, not covered, or not yet	g of the most commonly prescribed drugs under the medical benefit reviewed and whether a prior authorization is required. For coverage	SEARCH TIPS: This is a large document, but you can search quickly and easily by clicking on	the binocular icon on your toolbar. It will then display a search box for you		
			ered, please complete the Exception to Coverage form found on the al submit to the Plan Pharmacy Services and for pharmacy submit to Navitus.	to type in the name of drug you want to locate. If you do not know the corre the n	ct spelling, you can start your search by entering just the first few letters of		
Benefit	Updated: 05/01/2024 J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
					VEOPOZ* (pozvírnab-bbfg)		
Medical	19376	VEOPOZ	pozelimab-bbfg	Yes, through the Plan Pharmacy Services	VeOPOz* (pozisima6-colg)	VECHOZ** (pozeimiso-sotg)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	11427	VILTEPSO	viltolarsen	None. Not Covered.	MITTPSO (vitolarsen)		
Medical	J1323	VIMIZIM	elosulfase (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Mucopolysaccharidosis IVA with authorization.	VIMIZIM feloculface)	VMM/ZIM feloculface)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	17321	VISCO-3 - non-preferred	hyaluronan or derivative	As of 08/01/202: HFALGAN, STRVISC, STRVISC ONE, HFMOVKS, and TRILLINON will be the preferred hybriumoric acid products and do not require prior subrication. Monoxing, travolane, Gel One, Gutheau, Geldone, Structus, S	355C0-3 (hydrornan or derkedve)	19500 3 Byphirionan or derivative)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO.
Medical	19999	VIVIMUSTA	bendamustine	Yes through the Plan Pharmacy Services	WWMUSTA (bendamustine)	WWMUSTA (bendamustine)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J3385	VPRIV	velaglucerase alfa (Intravenous)	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Medical Geneticist or other prescriber specialized in the treatment of Gaucher DX with authorization.	yPRIV (volugiuserase alfa)	VPRN (velaglucerase alfa)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J3032	VYEPTI	eptinezumab-jjmr	Yes through the Plan Pharmacy Services	VYEPTI (eptinezumab)	VYEPTI (eptinezumab)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs.
Medical	J3401	VYJUVEK	beremagene geperpavec-svdt	Yes, through the Plan Pharmacy Services.	WENEK** (beremagene generoaver-outs)	Y/U.VEK** (beremagene geperoavec.svdt)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 Z), Chapter 13, 550 Drugs and Biologicals for drugs.
Medical	11429	VYONDYS 53	golodirsen	None. Not Covered.	VYONDYS 53 (golodirsen)		
Medical	J9332	VYVGART	efgartigimod alfa-fcab	Yes, through the Plan Pharmacy Services. Must be prescribed by or in consultation with a neurologist.	V/VGART (efgertigmoid)	VfVGART (efgartgimod-alfa-fcab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100 2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9334	VYVGART-HYTRULO	efgartigimod alfa-fcab and hyaluronidase-qvfc	Yes, through the Plan Pharmacy Services.	Wygart* Hydrulo (efgartigimod alfa-fcab and hyaluronislase-gyfc)	Wugart® Hytrulo (elgartigimod alfa-frah and hyaluronidase-oyfe)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.1). Chapter 15, §50 Drugs and Biologicals for drugs
Medical	19153	VYXEOS	daunorubicin and cytarabine – liposome	Yes, through the Plan Pharmacy Services	VYXEOS (daunorubidn and cytarabine ~ Eposome)	VYXEOS (daunorubicin and cytarabine-liposome)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100.2), Chapter 15, 550 Drugs and Biologicals for drugs
Pharmacy		VYZULTA	latanoprostene bunod	PHARMACY BENEFIT ONLY. Yes, through Navitus.	VYZULTA (latanoprostene bunod)	VYZULTA (latanoprostene bunod)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	13590	WYOST	denosumab	EFFECTIVE 05/31/2024. Yes, through the Plan Pharmacy Services	WYOST (deno sumab)	WYOST (denosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions Wi, IL, MO
Medical	J0218	XENPOZYME	olipudase alfa	Yes, through the Plan Pharmacy Services	XENPOZYME™ (olipudase alfa)	XENPOZYME™ (olipudase alfa)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Aurisdictions WI, IL, MO
Medical	J1558	XEMBIFY (SCIG)	Immune globulin	Yes, through the Plan Pharmacy Services	XEMBIPY (SCIG)	YEMBIFY (SCIG)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	10588	XEOMIN	IncobotulinumtoxinA	No prior authorization is required.	XEOMIN (incobotulinumtoxinA)		MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	10897	XGEVA	denosumab	Yes, through the Plan Pharmacy Services	XGEVA (denosumab)	XGEVA (demosumab)	MAPD Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WII, II, MD
Medical	13299	XIPERE	triamcinolone acetonide injectable suspension	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) an opthamalogist specialist with authorization.	XIPFRE (triamcinolone acotonide injectable suspension)	33PERE (triamcinitone acetonide injectable suspension).	MAPO Prior Authorization based on National Coverage Determination (NCO), Local Coverage Determinations (LCOs), and Local Coverage Antides (LCAs) for guidance where applicable for Jurisdictions VII, II, MO
Medical	12357	XOLAIR	omalizumab, 5mg	Yes, through the Plan Pharmacy Services. Restricted to a Allergy, Pulmonology, Immunology or Dermatology specialist with authorization.	XOLAIR fomalizumabl	KOLAR fomalizumab)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Autodictions VII, II, NO
Medical	19228	YERVOY	ipilimumab	Yes, through the Plan Pharmacy Services	YERVOY (iplimumab)	YERVOY (ipimumab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	Q2041	YESCARTA	axicabtagene ciloleucel	Yes, through the Plan Pharmacy Services	YESCARTA (axicabtagene citoloscel)	YESCARTA (axicabtagene citoleucel)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals for drugs
Medical	J9352	YONDELIS	trabectedin	Yes, through the Plan Pharmacy Services	YONDFUS (trabectedin)	YONDFUS (trabectedin)	MAYO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drup
Medical	Q5101	ZARXIO	filgrastim-ayow	EFFECTIVE 01/01/2023: Nivestym and Zaorio are the preferred Figraatin products and do not require prior authorization. Neupogen, Refeuko and Granix, require prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria.	ZARNO (filipractim-agenet)	ZAROXO (Rigrastim-ayour)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-3), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	10256	ZEMAIRA/PROLASTIN-C	alpha-1-proteinase inhibitor (human)	Yes through the Plan Pharmacy Services. Restricted to Pulmonology specialist with authorization.	ZEMAIBA/PROLASTIC-C (alpha-1-proteinase inhibitor)	ZEMARRA/PROLASTIC-C (alpha-1-proteinase inhibitor)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19223	ZEPZELCA	lurbinectedin	Yes, through the Plan Pharmacy Services	ZEPZECA (Jurbinectedio)	2E92ELCA (lurbinectedin)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q5120	ZIEXTENZO	pegfligrastim-bmez	EFFECTIVE DJ/01/2024: FUR PHILA and NYVEPRIA are the preferred Pegiliparstim products and do not require prior authorization. Must have a faller tial of ZEXTENZO AND PULPHILA BORDO coverage of Neulasta. UDENCYA, PTLNETRA, STIMMERNO and ZEXTENZO require a prior authorization through the Plan Pharmacy Services. Please see Medical Policy for criteria	ZECTENZO (pogfligractim-breez)	ZEXTENZO (poglifracim-hver)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-3), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	Q5118	ZIRABEV	bevadzumab-buzr	As of 03/02/2024: Zirabev is the preferred Seveschumab product and does not require prior authorization. Avaitin, Alymoy, Mexis and Vyagaima prior authorization is required through the Plan Hamanay Services. ""Prior authorization for bevolcturable is not required when used for ophitalmological indication." "See the ALTMSS (bevolcturable) Policy for a list of applicable ophthalmological diagnosis.	28ABTV Stanislamah basi	2PARCY (behiclowesh best)	MAPO Prior Authorization based on National Coverage Determination (NCD), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs) for guidance where applicable for Jurisdictions WI, II, MO
Medical	13399	ZOLGENSMA	onasemnogene abeparvovic xioli	Yes, through the Plan Pharmacy Services. Restricted to (in at least consultation with) a Neurologist with expertise in the diagnosis of Spina Muscular Atrophy (SMA) with authorization.	201GENSMA (onatemnogre abeganosículo)	201GENSMA (on ssemnogene abenarvovic)	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	19359	ZYNLONTA	Ioncastuximab tesirine	Yes, through the Plan Pharmacy Services	ZYNLONTA (koncastunimab)	ZYNLONTA (loncasturimab)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-7), Chapter 15, 550 Drugs and Biologicals for drugs
Medical	J3590, C9399	ZYNTEGLO	betibeglogene autotemcel	Yes, through the Plan Pharmacy Services	ZYNTEGLO* (betibeglogene autotemcel).	ZYNTEGLO* (betibeglogene autotemcel).	MAPD Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, \$50 Drugs and Biologicals for drugs
Medical	19345	ZYNYZ	retifanlimab-dlwr	Yes, through the Plan Pharmacy Services.	ZWVZ** (ortizolimik-dwr)	ZVNVZ ^m (rotifanimab-dher)	MAPO Prior Authorization needed outlined in the Medicare Benefit Policy Manual (Pub. 100-1), Chapter 15, 550 Drugs and Biologicals for drugs.

	DeanHeath ion	IN.	ECTABLE MEDICINES	SEARCH TIPS:			
		Dean Health Man website for medical submit to the Man Pharmacy Services and for pharmacy su Navitus. Updated: 05/02/2024		If the same of the			
	Opusies. 63/01/2124						
Benefit	J Code	Brand Names	Generic names	Prior Authorization or Restrictions	Policy	Prior Authorization Form	MAPD
	Notes:						
				There are claim specific edits for many of these drugs. The edits limit the uses of these drugs to approved indications and dosages. In addition, Dean Health		nne meisen man wei not cower u.s. mote and umg zeimmisstation (mos) approved drugs that are new to the market until the Pharmacy and Therapeutics (P&T) Committee formally reviews and grants approval,	